

**Department of Veterans Affairs
Veterans Health Administration
Office of Quality & Performance**

Title: MANAGEMENT OF DYSLIPIDEMIA – Update 2006

Citation:	Management of Dyslipidemia in the Primary Care Setting. Washington, DC: VA/DoD Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs and Health Affairs, Department of Defense, October 2001.(Update 2006) Office of Quality and Performance publication 10Q-CPG/Lipids-05.	
Completion Date:	December 2005	
Release Date:	August 2006	
Source(s):	Washington (DC): The Guideline for the Management of Dyslipidemia in the Primary Care Setting was developed by and for clinicians from the Department of Veterans Affairs (VA) and the Department of Defense (DoD); 2005.	
Adaptation:	<p>The guideline draws, in part, from :</p> <ul style="list-style-type: none"> • USPSTF 2001: U.S. Preventive Services Task Force. Screening for Lipid Disorders: Recommendations and Rationale. Am J Prev Med 2001;20(3S):73-76 (http://www.elsevier.com/locate/ajpmonline). • NCEP ATP-III, 2002: Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) final report. Circulation 2002, 106, (25), 3143-421. 	
Guideline Status:	This is the current version of the guideline update -2006. An update is targeted for 2009.	
Developer(s):	Veterans Health Administration (VHA), Department of Veterans Affairs (VA) - Federal Government Agency [U.S.] Department of Defense (DoD) - Federal Government Agency [US]	
Funding Source:	United States Government	
Committee:	The Management of Dyslipidemia Working Group	
Group Composition:	The list of contributors to this guideline includes nurses, cardiologists, endocrinologists, internal medicine and primary care physicians, pharmacists, dieticians and experts in the field of guideline and algorithm development.	
Disease Condition:	Dyslipidemia	
Category:	Assessment, Diagnosis, Treatment, Management	
Intended Users:	Clinical Staff including Physicians; Nurses; Nurse Practitioners; Physician Assistants	
Target Population:	Any person with dyslipidemia who is eligible for care in the VA or DoD health care delivery system.	
Contact Person(s):	VHA : John R. Downs, MD Section Chief, General Internal Medicine Research /Verdict	DoD: Vincent F. Carr, Col, USAF, MC, CFS DO, MSA, FACC Chief Consultant for Internal Medicine Services

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Goals/Objectives:	<ul style="list-style-type: none"> To describe the critical decision points in the management of dyslipidemia To provide a clear and comprehensive guideline incorporating current information and practices for practitioners throughout the DoD and Veterans Health Administration system To improve local management of patients with dyslipidemia and improve patient outcome 	
Interventions And Practices:	<p>The Guideline is a single module, which address three aspects of lipid-related care:</p> <ul style="list-style-type: none"> Algorithm A: Dyslipidemia Screening Algorithm B: Management of Dyslipidemia - Initiation of Therapy Algorithm C: Management of Dyslipidemia - Follow-up of Therapy <p>This guideline also contains appendices that provide more information on the spectrum of treatment options, and give details on pharmacologic and other interventions.</p> <p>Appendix A: Guideline Development Process Appendix B: 10-Year CV-Risk Assessment Appendix C: Medical Nutrition Therapy Appendix D: Exercise Appendix E: Pharmacologic Therapy: Drug Information Appendix F: Pharmacologic Therapy: Summary of Supporting Studies</p>	
Outcomes Considered:	Rate and degree of progression of dyslipidemia.	
Major Recommendations:	Presentation of the algorithms is intended to assist the clinician in reviewing and identifying key points that are comprehensively discussed in the guideline document.	
Clinical Algorithms:	Dyslipidemia Screening (Algorithm A) Management of Dyslipidemia (Algorithm B) Management of Dyslipidemia (Algorithm C)	
Type Of Evidence:	<p>The guideline is supported by the literature in a majority of areas, with evidence-based tables and references throughout the document. The evidence consists of key clinical randomized controlled trials and longitudinal studies in the area of dyslipidemia. Where existing literature is ambiguous or conflicting, or where scientific data are lacking on an issue, recommendations are based on the expert panel's opinion and clinical experience. The guideline contains a bibliography and discussion of the evidence supporting each recommendation.</p>	
Description Of Methods To Collect Evidence:	<p>The literature supporting the decision points and directives in this guideline is referenced in Evidence Tables and Discussions. The working group leaders were solicited for input on focal issues prior to a review of the literature. A search was carried out using the National Library of Medicine's (NLM) MEDLINE database. Electronic searches of the Cochrane Controlled Trials Register (www.update-software.com) were undertaken. Papers selected for further review were those published in English-language peer-</p>	

	<p>reviewed journals between 2000 and 2005. Preference was given to papers based on randomized, controlled clinical trials, or nonrandomized case-control studies. Studies involving meta-analyses were also reviewed. Selected articles were identified for inclusion in a table of information that was provided to each expert participant. The table of information contained: Title, Author(s), Publication type, Abstract and Source. Copies of these tables were made available to all participants. In addition, the assembled experts suggested numerous additional references. Copies of specific articles were provided to participants on an as-needed basis. This document includes references through August 2005. More recent information will be included in the next guideline update</p>																		
<p>Methods To Assess The Quality And Strength Of The Evidence:</p>	<p>Evidence-based practice involves integrating clinical expertise with the best available clinical evidence derived from systematic research. The working group reviewed the articles for relevance and graded the evidence using the rating scheme published in the U.S. Preventive Services Task Force (U.S. PSTF) Guide to Clinical Preventive Services, Second Edition (1996), displayed in Table 1. The experts themselves formulated Quality of Evidence (QE) ratings after an orientation and tutorial on the evidence grading process. Each reference was appraised for scientific merit, clinical relevance, and applicability to the populations served by the Federal health care system. The QE rating is based on experimental design and overall quality.</p> <p>The U.S. PSTF grading process suggests assigning a second grade that reflects the strength of the recommendation (SR) for each appraised study, and this grading system was also used by the dyslipidemia experts to develop recommendations.</p> <p>The SR (displayed in Table 2) is influenced primarily by the significance of the scientific evidence. Other factors that were taken into consideration when making the SR determination are standards of care, policy concerns, and cost of care.</p>																		
	<p>TABLE 1: Quality of Evidence (QE)</p> <table> <tr> <td>I</td><td>At least one properly done RCT</td></tr> <tr> <td>II-1</td><td>Well designed controlled trial without randomization</td></tr> <tr> <td>II-2</td><td>Well designed cohort or case-control analytic study</td></tr> <tr> <td>II-3</td><td>Multiple time series, dramatic results of uncontrolled experiment</td></tr> <tr> <td>III</td><td>Opinion of respected authorities, case reports, and expert committees</td></tr> </table> <p>TABLE 2: Overall Quality</p> <table> <tr> <td>Good</td><td>High grade evidence (I or II-1) directly linked to health outcome</td></tr> <tr> <td>Fair</td><td>High grade evidence (I or II-1) linked to intermediate outcome; or grade evidence (II-2 or II-3) directly linked to health outcome</td></tr> <tr> <td>Poor</td><td>Level III evidence or no linkage of evidence to health outcome</td></tr> </table> <p>TABLE 3: Net Effect of the Intervention</p> <table> <tr> <td>Substantial</td><td>More than a small relative impact on a frequent condition with a substantial burden of suffering; or</td></tr> </table>	I	At least one properly done RCT	II-1	Well designed controlled trial without randomization	II-2	Well designed cohort or case-control analytic study	II-3	Multiple time series, dramatic results of uncontrolled experiment	III	Opinion of respected authorities, case reports, and expert committees	Good	High grade evidence (I or II-1) directly linked to health outcome	Fair	High grade evidence (I or II-1) linked to intermediate outcome; or grade evidence (II-2 or II-3) directly linked to health outcome	Poor	Level III evidence or no linkage of evidence to health outcome	Substantial	More than a small relative impact on a frequent condition with a substantial burden of suffering; or
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		A large impact on an infrequent condition with a significant impact on the individual patient level.
	Moderate	A small relative impact on a frequent condition with a substantial burden of suffering; or A moderate impact on an infrequent condition with a significant impact on the individual patient level.
	Small	A negligible relative impact on a frequent condition with a substantial burden of suffering; or A small impact on an infrequent condition with a significant impact on the individual patient level.
	Zero Or Negative	Negative impact on patients; or No relative impact on either a frequent condition with a substantial burden of suffering; or an infrequent condition with a significant impact on the individual patient level.
	TABLE 4: Grade the Recommendation	
	A	A strong recommendation that the intervention is always indicated and acceptable
	B	A recommendation that the intervention may be useful/effective
	C	A recommendation that the intervention may be considered
	D	A recommendation that a procedure may be considered not useful/effective, or may be harmful
	I	Insufficient evidence to recommend for or against - the clinician will use clinical judgment
Review Methods:	Peer Review	
Qualifying Statements:	Clinical practice guidelines, which are increasingly being used in health care, are seen by many as potential solutions to inefficiency and inappropriate variations in care. Guidelines should be evidenced-based as well as based upon explicit criteria to ensure consensus regarding their internal validity. However, it must be remembered that the use of guidelines must always be in the context of a health care provider's clinical judgment in the care of a particular patient. For that reason, the guidelines may be viewed as an educational tool analogous to textbooks and journals, but in a more user-friendly format.	
Guideline Availability:	Electronic copies available from the OQP website Print copies available from: The Office of Quality and Performance (10Q) Veterans Health Administration, Department of Veterans Affairs 810 Vermont, NW Washington, DC 20420	
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